Medical Home Group

Recognition Workgroup Meeting
May 2, 2011

Notes

Introductions

Overview of Goals

- Are on-track with updated goals
- Still need guidance on the anti-trust questions

Fred Olson, BCBS MT

Pilot Project at Billings Clinic and Western Montana Clinic

- 2 years with primary care physicians only
- Assigned patients to physician based on a 2-year look back
- Only members with underwritten groups
- Tried with self-funded- difficult to participate 21/21 groups declined
- 1600 members with 1/6 chronic conditions
- Success= one time per year visit
- Starting to assess:
    - Compared to unmanaged care= 14,000 members
    - Disease management program- nurse care coordinator at BCBS= 1540 members
      Disenroll medical home patients from disease management
- Now looking at cost/quality metrics
- In spite of clinic coordinator fee, not costing any more than other
    - In second year, cost goes down
- North Dakota- program going for 5 years
    - 80% of BCBS members are in medical homes
    - Cost per member per year goes down $400 per year
- Access- in pilot increased visitation 60-85% for office visit
- At Billings Clinic- top 4 PCPs are in Urgent Care
- How are patients informed of attribution?
    - Pilot is beginning of relationship building- aligning goals together
    - Process- had electronic patient registry several years before
    - Patient asked PCP- if hesitant, would be assigned
    - Other states- patients receive letter welcome to medical home, encourage to develop relationship
- Cannot manage if patients are not attributed to provider
    - Payer only has claims data

    - Visits at Urgent Cares do not count
- National average for patients switching – 20% over 3 years
- Has there been a shared savings discussion with pilot?
    - No talk
    - BCBS did hire care managers in clinics
- Importance of hospitalization data and ER visits
    - BCBS is cranking that out
    - Providers can see if there are readmits or ER visits
    - Providers have report cards on this anyway
- Are there plans to publish or report lessons learned?
- Patient registry needs to be improved
    - Data to provider in something close to real time
- Payers have claims data, need to beef up with clinical data
- Importance of primary care providers seeing data on patient population
- Change in benefit levels?
    - No, driven by data
    - There are some other changes going on with value-based benefit design

Four payment models

1. Fee for service
2. Fee for performance
3. Pay for performance
4. Shared savings

Ways to pay provider

1. Salary
2. Fee for service
3. Capitated
4. Pay for performance

PROPOSAL: Recognition as medical home by payer if provider reaches Level 1,2,3 NCQA recognition

Comments:

Laurie Francis: Would payers lead providers beyond getting recognized?

Joe Sofianek: Needs to be upfront incentive. Takes time to get to level 3. Would also like to see pay for outcomes down the road or built into model.

Doug Carr: Contingent on good faith effort to report on quality measures. Do not want to encourage cottage industry in healthcare. Don't promote independent projects, but continue to work toward statewide system.

Paul Cook: Develop outcome standards. Level playing field of providers to help get to level 1. Use HealthShare Montana. Make sure everyone has access to registry.

Janice Gomersall: Agree NCQA standards are good place to start. New York used a graduated system that capped recognition first year. Do not want to have practices spending time on paperwork and not infrastructure and system change. New York- 12 months for level 1 and then 12 months again for level 2. Should have all payers agree on single per member per month reimbursement.

Denise Brunett: When using access to health care, all sizes of clinics need to be represented. The success is seen at regional pediatric specialty clinics where care coordinators were part of the staff. Providing good care is vital, as is health care coverage. When families of children with special health care needs are juggling as much as they are, a person assuring coverage, payment and access to needed

Nancy Wikle: Is NCQA necessary for recognition? It is what we need to give us good measure of patient-centered care? Can we look at ways to share resources- share case managers between practices? Make sure we are focusing on outreach to rural population. Give small and rural practices the chance to be rewarded for improvements.

How do we measure improvement? How do we measure management and control of populations while keeping in mind patient at the center. How do we change patient behavior along with provider behavior?

Patient attribution is highly important for Medicaid adults. By the time the adult becomes eligible for Medicaid, they are very sick and usually very sick. How do we measure their improved level of care?

Question to Nancy: Is there inappropriate utilization of ER in Passport program? The biggest key is access to a primary care provider. 72% of Passport participants choose a primary care doctor.

Sense of group: To begin change, providers need to know data about their patient population.

What does NCQA do for the patients? Should you get paid for not improving care?

Fred Olson:

Does not favor requiring NCQA because it would likely exclude all small practices that are doing a good job of providing quality, low-cost care.

Value in showing providers their performance. We think it is good enough if they are interested.

What is the duty of the insurer to NCQA if we choose this route? What is the responsibility and process of the provider to notify the insurer?

More interested in pay for performance model. Need to build a common language among providers and carriers.

Bob Shepard:

Board certification of physicians is what assured that they are good specialists.
NCQA – many practices are already working toward recognition.

Need to get to small practices:

1. Seed money
2. Platform for registry functions
3. BCBS data system has registry functions. Don't have to maintain IT capacity in office.
4. NWHS data system records quality measures in real time. Able to get data set to providers.
5. Payers need to be able to provide information to providers.
6. We don't want paperwork without systematic change. Want practices to go through process honestly.

Todd Lovshin:

Very interested in fully insured side of business. Company is primary made up of self-insured business.

Like NCQA because it is already established- easier than creating new standards

For self-insured, mining of data is more difficult

Rob Stenger:

Staffed a working group similar to this in Oregon. They did not like NCQA standards and instead made their own. Found NCQA to be overly burdensome.
Today there is no multi-payer project in Oregon.

Oregon used a leaner set of criteria with less administrative burden.

How do we get there?

Facilitate providers getting to level 1.

Recognize that there is an investment before getting level 1 designation.

What happens on provider end if they want to be included? Options:
1. Contact each payer to let know they have level 1
2. Contact central registry to let know they have level 1
3. Do they have to reach level 1 status first?

Possible grants. Example, Federal- Centers for Innovation